AMENDED IN ASSEMBLY MAY 6, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1542

Introduced by Committee on Health (Jones (Chair), Adams, Ammiano, Block, Carter, De La Torre, De Leon, Hayashi, Hernandez, Bonnie Lowenthal, Nava, V. Manuel Perez, and Salas)

March 4, 2009

An act to add Part 3.6 (commencing with Section 15950) to Division 9 of the Welfare and Institutions Code, relating to health care services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1542, as amended, Committee on Health. Medical ~~records: centralized location.~~ *homes.*

Existing law imposes various functions and duties on the State Department of Health Care Services with respect to the administration and oversight of various health programs and facilities, including the Medi-Cal program.

This bill would establish the Patient-Centered Medical Home Act of 2009 to encourage health care providers and patients to partner in a patient-centered medical home, as defined, ~~relating to a centralized, comprehensive location for a patient's medical records~~ *that promotes access to high-quality, comprehensive care*.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Part 3.6 (commencing with Section 15950) is added to Division 9 of the Welfare and Institutions Code, to read:

PART 3.6. PATIENT-CENTERED MEDICAL HOME ACT OF 2009

15950. (a) This part shall be known, and may be cited, as the Patient-Centered Medical Home Act of 2009.

(b) It is the intent of the Legislature to encourage health care providers and patients to partner in a patient-centered medical home that promotes access to ~~high quality~~ *high-quality*, comprehensive care and ultimately to ensure that all Californians have a medical home.

(c) It is further the intent of the legislature that any California provider, practice, or institution calling itself a medical home adhere to nationally recognized quality standards that will do all of the following:

(1) Reduce disparities in health care access, delivery, and health care outcomes.

(2) Improve quality of health care and lower health care costs, thereby creating savings to allow more Californians to have health care coverage and to provide for the sustainability of the health care system.

(3) Meet the National Committee for Quality Assurance (NCQA) definition and characteristics of a medical home.

15951. As used in this part, the following terms have the following meanings:

(a) "Medical home" means a team approach to providing health care that ~~originates in a primary care setting,~~ fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient's family, utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential, maintains a ~~centralized,~~ comprehensive record of all health-related services to promote continuity of care, and has all of the characteristics that qualify it as a medical home.

(b) "National Committee for Quality Assurance" means the nationally recognized, independent nonprofit organization that

measures the quality and performance of health care and health care plans in the United States, provides accreditation, certification, and recognition of programs for health care plans and programs, and is recognized in California as an accrediting organization for commercial and Medi-Cal-managed care organizations.

(c) "Personal provider" means the patient's first point of contact in the health care system with a primary care provider who identifies the patient's health needs, and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.

(d) "Primary care" means health care that emphasizes providing for a patient's general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.

15952. A "medical home," for the purposes of this part, meets the standards set forth by the National Committee for Quality Assurance, and includes all of the following characteristics:

(a) An ongoing personal provider for each patient trained to provide first contact, continuous, and comprehensive care.

(b) The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.

(c) The personal provider is responsible for providing for all of a patient's health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.

(d) Care is coordinated and integrated across all elements of the complex health care system and the patient's community. Care is facilitated by registries, information technology, health information exchanges, and other means to ensure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.

(e) All of the following quality and safety components:

(1) Provider-directed medical practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient's family.

(2) Evidence-based medicine and clinical decision support tools guide decisionmaking.

(3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

(4) Patients actively participate in decisionmaking and feedback is sought to ensure that the patients' expectations are being met.

(5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

(6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient-centered services consistent with the medical home model.

(7) Patients and families participate in quality improvement activities at the practice level.

(f) Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient's personal provider, and practice staff.

(g) The payment system appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure framework of the medical home does all of the following:

(1) Reflects the value of provider and nonprovider staff and patient-centered care management work that is in addition to the face-to-face visit.

(2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.

(3) Supports adoption and use of health information technology for quality improvement.

(4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.

(5) Recognizes the value of provider work associated with remote monitoring of clinical data using technology.

(6) Allows for separate fee-for-service payments for face-to-face visits. Payments for health care management services that are in addition to the face-to-face visit do not result in a reduction in the payments for face-to-face visits.

(7) Recognizes case mix differences in the patient population being treated within the practice.

(8) Allows providers to share in savings from reduced hospitalizations associated with provider-guided health care management in the office setting.

(9) Allows for additional payments for achieving measurable and continuous quality improvements.

O